APPENDIX D

July 2002 329-G Planning Group Meeting Summary

Summary

Integration of Children's Services
Planning Committee Session

July 17, 2002
Virginia Department of Mental Health,
Mental Retardation and Substance Abuse Services

Present: Joanne Boise, Lanett Brailey, Angie Brown, Sandy Bryant, Claire Butler, Velda Carrington, Barbara Carter, Mary Cole, Pam Cooper, Margaret Crowe, Val Cuffee, Charline Davidson, Mary Ann Discenza, Scott Dowden, Betsy Draine, Stacie Fisher, Vicky Fisher, Jim Gillespie, Lee Goldman, Catherine Hancock, Camille Harris, Lelia Hopper, Joyce Kube, John Makandwire, Jim Martinez, Dan McCauley, Pam McCune, Martha Mead, Hope Merrick, Wanda Pruett, Linda Redmond, Shirley Ricks, Daniel Rigsby, Frank Rogers, Barbara Shue, Joe Stallings, Belinda Stokes, Lisa Sykes, James Thomas, Therese Wolfe, Kristi Wright, and Judy Burtner, facilitator.

Objectives

1. Develop a vision that will provide a description of the characteristics of an integrated system
2. Identify the goal areas around which work will have to be accomplished to make the vision a reality

Ground Rules

Participants agreed to the use of the following ground rules:

- Take care of your own needs
- Focus – an integrated system "we" will build
- Focus – the future
- Work toward consensus
- Search for common ground
- Use the full name for acronyms
- Keep side conversations to a minimum
- Cellphones on "stun" – leave the room to handle calls, then return
- Work to stay present, focused and conscious

Completions to the Sentence

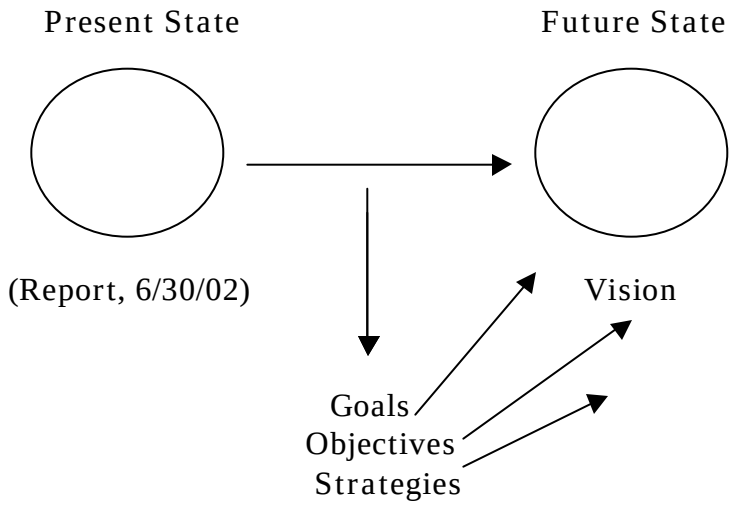
During introductions, participants contributed the following to the completion of the sentence: If our system were truly integrated, it would:

- Provide children and families with what they need.
- Work.
- Provide immediate access for children and their families with wrap-around services, treatment and collaboration.

- Enable juvenile and circuit court judges to hold entities responsible when referring children for services and that they are available when needed.
- See that when my child is born, I would be sent to the "right" person immediately to address my issues and concerns.
- Have kids be involved at all levels – policymaking, implementation and feedback.
- See that all families would have immediate access to services.
- Be easy for parents to access.
- Improve/assist with the relationship between the child and their parents.
- Not blame the parents.
- Develop a way to integrate funding streams for services.
- Not be difficult to access rates and services.
- Be truly integrated.
- Provide more service providers and fewer administrators.
- Not have duplication of services within agencies and/or between agencies.
- Include prevention services in the broadest continuum.
- Be as flexible as possible to meet needs and access services.
- Include effective services for all youth including those in juvenile facilities, detention and prisons, etc.
- Not matter what portal I entered the system I would get what I needed.
- Serve child/adolescent and families by the level of need and be preventive.
- Transcend identify of individual agencies to provide services.
- Enable service delivery across jurisdictional lines.
- Be seamless.
- See that the need for mental health, mental retardation and substance abuse services would not be a stigma or seen as stigmatizing.
- Be strength-based at every level.
- Make a statistical/measurable difference in the lives of children and their families.
- Be immediately available without ability to pay with courts not seen as a cure-all.
- Cross all disability areas and services would be provided based on need and not on just what's available.
- Appear seamless to the consumer – there would be a sense of joint ownership by all providers.
- Provide for the holistic needs of the child to be address, not provide fragmented services.
- Focus on the actual delivery of services, not just the payment for services.
- Be flexible and responsive to the total needs of the child and his/her family.

- Be no "wrong door." There would be service for the family and not just the child and the same services would be provided consistently statewide.
- Be a less crisis-management system for mental health services.
- Be more of a one-stop shopping concept. Regardless of where the child would enter the system, the assessment would be uniform
- Not just be integrated at the services level but at the state level too. Departments/agencies would integrate data planning, policy development functions with the involvement of parents (possibly through the use of stipends) at all levels.
- An evidence-based program focused on the needs of the family with expected improvements.
- Provide a place for parents to call/go (even if they have no resources or they are not eligible) to get assistance in addressing their needs in the most efficient cost-benefit manner.

Defining the Future State (Vision)
Participants were reminded of the Gap Analysis Model:



Participants, working in seven small groups, developed a response to the following question:

> *If we had a truly integrated system relative to planning, services, and policy for children/adolescents and their families, it would have the following characteristics:*

Small group reports follow.

<u>Group #1</u>

- Has adequate resources – money, providers, information – that will enable access to a full spectrum of services statewide, based on need

- Services are immediately accessible with knowledgeable and empowered case managers who operate across service disciplines and jurisdictions. Continuum of care with transition "ombudsman" – all disabilities, all ages
- Child and family focused without regard to funding streams and not based on special needs or disabilities
- Not crisis-oriented and includes prevention
- Culturally competent with child and parent involvement
- Balanced/stream-lined central governance for policy, procedures, directions, requirements and information collection with evidence based best practices

Group #2

- One Door
    - Easy access without funding or service category barriers
    - Knowledgeable person guiding families
    - Single entity providing service coordination of all treatment services, including prevention
- CQI (Comprehensive Quality Improvement) – evidence based, includes consumers and families at all levels without stifling creativity or innovative practices.

Group #3

- Easy access, free or sliding fees
- Continuum of care with transition "passport" – (ombudsman)
- Integrated funding across disabilities
- Uniform assessment across agencies
- Restructuring of agencies that serve children
- Strengths-based service delivery
- View parents as experts
- More resources and services
- Services available at community sites
- Standardize availability of services across the state
- Determine program effectiveness relative to outcome
- Provide intervention based effectiveness rather than cost
- Focus on prevention/early amelioration of symptoms before crisis
- Provide culturally competent care/deliver services equally to all
- Disclose treatment options/best practices to parents

Group #4

- Clear points of access – resource directory
- Uniform interagency assessment tool

- Shared data system
- Rapid access
- Family-centered services
- Interagency forum for operational issues

    - Coordinated licensing
    - Elimination of duplication of services
    - Implementation of needed services

- Need for community needs assessment and community plan
- Statewide consistency in available services

Group #5

- Services are known and accessible
- Better training and pay for qualified service providers to reduce burnout and turnover and to help recruit
- Visible, easy access from anywhere in any community across Virginia regardless of ability to pay (e.g., one number in every locality to call if you're worried about your child)
- Full range of services for children and families with more focus on prevention and early intervention end (including screening and assessment)
- Child plus family involvement and support including training (e.g., peer support groups, mentors, how to advocate for your child)
- Creative, flexible, individualized services based on level of need (not labels)
- Does not stigmatize parents or families and is visible
- Integrated application and record-keeping process
- A system that continually challenges the status quo – process for continuous improvement

Group #6

- Assure safety of child (accurate and appropriate diagnosis, medications, treatment and monitoring, services/treatment)
- Proven, cost effective programs
- Flexible to meet individual needs
- Accessible, uniform service provision across state that is understandable for all families
- Focus on early intervention/prevention as well as treatment/services – not crisis-oriented
- Assure coordinated, cross-agency training of providers – highly qualified, competent professionals for all disabilities
- Control data bases – uniform documentation and forms – easy access by professionals
- Flexible (even merged) funding streams

- Futuristic, proactive learning from today to projecting for future – from family and therapist for individual child to statewide policy and planning
- Culturally competent for all races, cultures and socio-economic groups

Group #7

- Strength-based, need-focused system that is culturally sensitive
- Centralize access to intake assessment and case management
    - Trained workers at front-end (too!)
    - Turf-neutral
- Wider array of services
    - Innovative and customized – individual/customized services
    - Reflect needs expressed by constituents
    - Prevention focused and proactive case management, public health mode
- Balance between services provision and administrative requirements
- Mainstream funding
- Multi-disciplinary "re-engineering" – rethink what multidisciplinary means and who else need to be included: police, legislators, business, SW/Y/etc.
- Transition from 0-3, 3-18, 18-adult

In the process of reviewing the above small group reports, participants agreed that the following concepts/phrases were ones that best described the **characteristics of an integrated system for children** they would like to see (to be wordsmithed at a later point):

- Easy access, free or sliding fees
- Centralized access to intake assessment and case management that is turf neutral with trained workers at front end
- Knowledgeable and empowered case managers who operate across service disciplines and jurisdictions.
- Continuum of care with transition "ombudsman" – all disabilities and all ages
- Balance between service provision and administrative requirements
- Balanced/stream-lined central governance for policy, procedures, direction, requirements and information collection with evidence based best practices
    - Single entity (as an umbrella)
    - Coordinated licensing

  - CQI – evidence based, without stifling creativity or innovative practices
  - Local/state coordination
  - Complaints/consumer satisfaction
  - Uniform assessment/data forms
  - Coordinated/interagency training
  - Forecasting, community needs assessment/development of community plans

- Concept of multidisciplinary/"re-engineering" rethought to include police, legislators, business, SW/Y, etc.
- Focus on early intervention/prevention as well as treatment services that are not crisis-oriented
- Better training and pay for qualified service providers to reduce burnout and turnover and to help recruit service providers
- Child and family focused
- Strengths-based service delivery
- Services at community sites
- Disclose treatment options/best practices to parents
- Child and family involvement and support including training (e.g., peer support groups, mentors, how to advocate for your child)
- Flexible, individualized services based on level of need (not labels)
- Does not stigmatize parents or families and is visible
- Clear point of access – no wrong door – resource directory
- Has adequate resources – money, providers, information – that will enable access to full spectrum of services statewide based on need
- Flexible (even merged) funding streams
- Restructuring of agencies that serve children
- Culturally competent

Achievable within what Time Frame

Participants were given the opportunity to express within what time frame they thought the above integrated system could be implemented. The various time frames and comments supporting those time frames follows:

<u>Two years</u>

- We don't have more time – children and families are in crisis now. Conditions are much more severe and children are coming into the system much younger
- This is a good time politically to deal with children's mental health. There are groups that will get behind this.
- There are initiatives occurring in some agencies that will support this effort. For example, the "feds" will be coming in next year in DSS to review how kids' mental health needs have been integrated into welfare and family well-being. The same interest from the

federal government may be occurring in other agencies that are receiving federal funds.
- There may be political will right now, but little money. However, some restructuring could be done without additional funds.

Three-four years

- There is political good will and professional good will. The CSA intent is good. We have the documentation to do it. There is the recognition it is important for children to have healthy families

Five to10 years

- I am optimistic that we can reach this vision in five years. CSA has started the process
- I am eternally hopeful. It took us 7 years to decentralize and it will be take 7 years to centralize
- I think SOLs will be a catalyst for this effort when it is realized who are the children that are being left behind and why
- There is a total interest in refocusing government funding toward cost savings. If we can move the focus away from short-term focus to long-term focus we have the data to support this effort
- We need to help people to understand that the ideas in CSA were never fully implemented
- We need to do show evidence based costs-savings
- We don't have more than 5 years – one year to do our planning and two biennial budgets to get it in place. Five years should be our goal.

10 – 15 years

- It will take 10 years to help the General Assembly to understand the cost-effectiveness and for them to make the dollars available to support the effort
- It will take some people in power whether in agencies or elsewhere to leave because of their difficulty in changing attitudes
- Some people will have to change jobs or leave before we will be able to fully implement this
- There is no impetus within agencies to raise children to the level needed to implement this

15 years plus

- It will take 15 years to obtain adequate resources so there is quality services that are consistently available across the state
- There is an issue of political will and the fact a one-term governor is limiting

- It may take 20 years to produce the cost effectiveness data needed to make our case

Identification of Possible Goal Areas

Participants, working in small groups, identified areas for which work would have to be done in order to build an integrated system with the above identified characteristics. Each small group was asked to identify a maximum of five areas and rank them in priority order by placing them on weighted sticky notes. The notes were collected and sorted into like groupings. In the identification of the areas, they were encouraged to use the following criteria:

- It would make the biggest difference or have the greatest impact on the development of an integrated system
- There is a sense of urgency – things are deteriorating, children and their families are not being well served with the present system
- It is within our reach and influence in thinking of all the networks and relationships that are available to us
- It needs to be done "first" in order to build momentum and support and belief by others that the effort can be realized

What follows are the possible goal areas in ranked order. Under each grouping name is the language that the small groups wrote on their sticky note along with the number rank. Items were ranked 1-5 with 5 being high.

Restructuring/building the system – 19 points

- Flesh out "centralized access" concept at local level (and all related issues) – one-stop access, cross-agency relationships, etc. – 5 points
- Establish interagency/stakeholder workgroups to determine common ground/practices and duplication – 4 points
- Build on present system – 4 points
- Centralized intake/ 1-800- # - 2 points
- Integrated database of resources (information and referral) – 2 points
- Develop sophisticated state and local communication systems across agencies – 1 point
- Restructure administration of children's services – 1 point

Funding Issues – 17 points

- Increase funding – 4 points
- Integrated funding streams across disabilities and jurisdictions; eliminate wasteful/stupid/conflicting regulations, etc. – 4 points
- Cost/benefit analysis of current expenditures, including CSA's and other pertinent data – 4 points

- Make better use of current funding and seek new dollars – for service development, training and pilots – 3 points
- Governance body to develop fluid pooled flexible funds – 1 point
- Expand community-based services for children and families and expand alternative funding streams – federal, corporate, and foundation funds – 1 point

Service needs – 15 points

- Regional needs assessment – 5 points
- Compile service needs for marketing/educating about why changes are required – 4 points
- Focus on prevention and early intervention with emphasis on cost benefit of these – 3 points
- Research and present integrated local and statewide system of care models to this group and key state leaders – 3 points

Buy-in from others – 15 points

- Buy-in from upper level management (SEC), key government officials and advocates – 5 points
- Commitment from SEC members to providing an integrated system of care (include consumers) – 5 points
- Assure "buy-in" from leaders. Educate agency heads, parents, local leaders, providers as to the role they must play – 5 points

Advocacy for mental health issues – 13 points

- Create a sense of urgency through nurturing and encouraging advocacy groups, developing a medial plan and having state agency heads meet to come to consensus – 5 points
- Recruit champions who are key decision makers – raise the public awareness, raise the importance within government – 5 points
- Find and cultivate a champion for children's mental health advocacy (i.e., a visible public figure) – 2 points
- Focus on private/public partnerships toward achieving increased visibility of CSA mental health issues – 1 point

Education of legislators and others on best practices and need – 11 points

- Education and training at all levels re: evidence-based, best practices, system of care (all levels = legislature, department heads and local and consumers) – 4 points
- Educate legislature, public, policy makers, etc. about need for restructuring streamlining – balancing system – 3 points
- Identify and disseminate information regarding best practices in service delivery and service coordination – 3 points

- Educate legislators on best practices – 1 point

Child and family involvement – 7 points

- Integrated consumer and family network (to inform all levels) (including Family Federation, NAMI, PEATC, ARC, Parent Resource Centers, PACCT, CSA parents, etc.) – 3 points
- Initiate a statewide family network with a toll-free number for system wide parent support and access to resources – 2 points
- Expand opportunities for child and family involvement – 2 points

Miscellaneous - items that didn't group easily with others

- Identify existing service providers (by region) – 3 points
- Developing knowledgeable creative, empowered workforce throughout the system (i.e., case managers, MDs, etc.) Resources for disseminating "best practices" – 2 points

Next Steps

It was agreed the above information (once wordsmithed and organized into a concise form) would be shared with the SEC at their August 28, 2002 meeting for reaction and additional input. Representatives from state agencies and statewide networks/organizations agreed to share the information with members of the SEC prior to their meeting so they would have time to reflect on it before offering their comments and input.

The next meeting of the planning committee will be **Tuesday, September 10, 2002**. The agenda will include the following:

- Input and comments received from SEC meeting (8-28-02)
- Agreement on the goal areas (how many and which ones). Note: The above listing may be reorganized
- Formation of workgroups to address the goal areas (one workgroup per goal area)
- Development of goals, objectives/strategies for each goal area
- Development of timelines for work

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